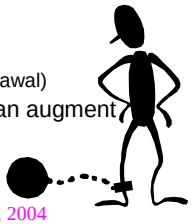
Sedative Detoxification

- Benzodiazepine detoxification may be complicated by:
  - Reactivation of a prior anxiety disorder
  - Rebound anxiety
  - Discontinuation syndrome (withdrawal)
- Cognitive-behavioral therapy can augment coping during detox



Chouinard, J Clin Psychiatry, 2004

Treatment

Behavioral treatments are the mainstay

- Individual counseling
  - **Cognitive-behavioral therapy**
  - **Relapse prevention**
- Psychoeducation
- Group counseling
- Family counseling
- Self-help groups

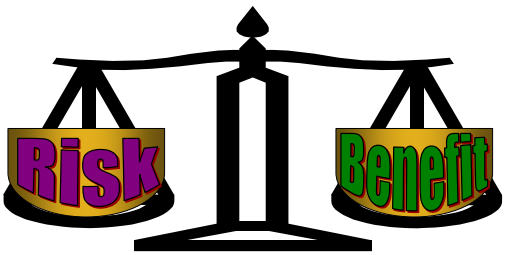
NIDA, 2001

Treatment

- When available, pharmacologic treatment can help
- A combination of behavioral and pharmacologic treatment is best
- Methadone or buprenorphine is effective for opioid analgesic dependence

NIDA, 2001

4. Balancing Benefit and Risk in Prescribing



Jean - Initial Presentation

- 33-year-old divorced truck company dispatcher
- Back pain since MVA 4 years ago
  - Bilateral L/S spine and paralumbar areas, non-rad.
  - Negative X-rays and MRI scan
- Initial treatment
  - PT - ultrasound, heat/cold, exercises
  - Chiropractic - helped initially, then ineffective
  - Ibuprofen 600mg tid (3 other NSAIDs were no better)
  - 8 oxycodone 5mg/acet 325mg per day - hard to taper
- Returned to work 3 months after MVA

Jean - Last 3 years

- Baseline pain - 2 to 3 on 0-to-10 scale
- Continues on ibuprofen 600 mg qd to tid
- Two exacerbations; no apparent cause
  - Tender lumbosacral spine
  - Paralumbar tenderness and palpable spasm
  - No radiation, normal neurologic exam
  - Treated with PT, oxycodone/acetaminophen 5mg/325mg qid, again hard to taper
  - Returned to work in 4 weeks

Jean - Today

- Exacerbation x 10 weeks, same hx/PE
- Tried PT 3 times - too painful
- Had been taking 8 oxycodone/acet. per day
- Opioids discontinued 2 weeks ago - diarrhea, agitation, sleeplessness
- Pain had been 5 to 8, now 7 to 9
- "I'd really want to go back to work, but if I can't get some relief I'm going to have to go on disability."

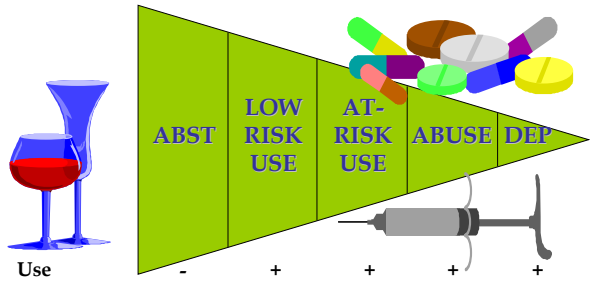
Jean - Substance Use and Psychiatric History

- Drank heavily until MVA/DWI 4 years ago
- Completed mandated intensive outpatient tx.
- Usually 4 twelve-ounce beers on Fri & Sat + 2 beers twice a week; now 3/day due to pain
- Used marijuana regularly until age 25; now once or twice a month
- Tried cocaine once - "That was way too good; I definitely could have gotten hooked on that."
- No psychiatric history

Question 1 - Opioid Diagnosis

Jean's recent opioid withdrawal and the difficulty discontinuing opioids suggest a DSM-IV diagnosis of:

1. Opioid abuse
2. Opioid dependence
3. Neither



Use	-	+	+	+	+
Consequences	-	-	-/+	+	++
Repetition	-	-	-	+	+
Loss of control, preoccupation, compulsivity, +/- physical dependence					+

Jean and Substance Use

<u>Opioids</u>

- Recent physical dependence
- No neg. consequences or loss of control
- Difficulty in tapering due to pain

<u>Alcohol</u>

- **Prior alcohol abuse, ? dependence**
- **Current - at least risky use**

Question 2 Indications for Opioids

Opioids should be considered for patients with chronic pain who have:

1. Moderate to severe pain
2. 1 + inadequate response to other treatments
3. 1 + 2 + significant functional disability
4. 1 + 2 + 3 + no active substance abuse/dep
5. 1 + 2 + 3 + 4 + no prior substance abuse/dep

Indications for Opioids

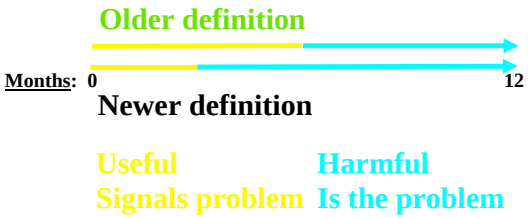
- Chronic pain of moderate to severe intensity
- Significant functional disability
- Inadequate response to other treatments

Pain Assessment - Intensity

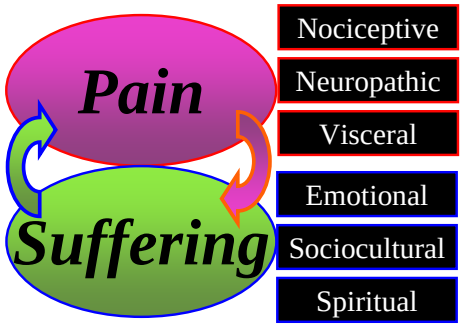
- Use standard scale such as 0 to 10 scale
  0 = no pain
  10 = worst pain imaginable such as …

- **Accept patients' reports**
- **Objective signs of acute pain are extinguished with chronic pain**

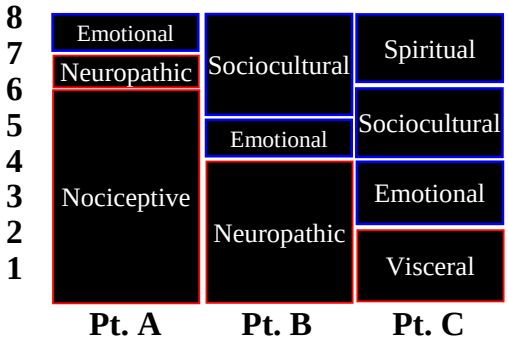
Acute vs. Chronic Pain



Sources of Pain



Three Patients with 8/10 Pain



Assessing Function

- Validated functional assessment tools
  - Chronic Pain Grade
    (VonKorff M et al. *Pain* 50:133-49,1992.)
  - Quebec Back Pain Disability Scale
    (Kopec JA et al. *J Clin Epidemiology* 49:151-61,1996.)
- **Questions**
  - **Bed days, missed work, curtailed activities**
  - **Activities patient can do / misses**
- **Appearance: dress, grooming, affect**

Attempting Other Treatments

- The treatment with most evidence of effectiveness for CLBP is exercise
- Adjunctive meds may be helpful
- Treat for psychiatric disorders, stress
- Distraction, relaxation, coping skills

Attempting Other Treatments

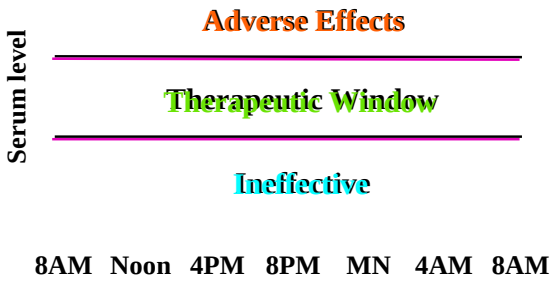
- TENS/PENS
- Invasive interventions
- CAM may be useful: massage, chiropractic, acupuncture, others
- NSAID's do not relieve severe pain
- COX-2 inhibitors are no more effective than other NSAIDs

Question 3 - Which opioids?

The safest and most effective opioids for treating chronic pain include:

1. Propoxyphene and pentazocine
2. Hydrocodone and immediate release oxycodone
3. Morphine sulfate-extended release tablets and transdermal fentanyl
4. All of the above

Advantages of Long-Acting Opioids



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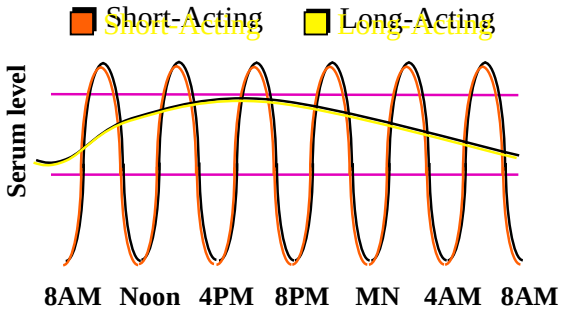

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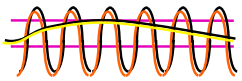

- More consistent analgesia
- Fewer adverse effects
- More tolerance to adverse effects
- Better sleep ➔ better daytime function
- Less euphoria, addiction, diversion

Opioid Regimen for Chronic Pain

- Long-acting opioid for baseline pain:
  - Hydromorphine-ERT
  - Morphine-ERT
  - Methadone
  - Oxycodone-ERT
  - Transdermal fentanyl
- Short-acting opioid for breakthrough pain:
  - Hydrocodone
  - Oxycodone
- **Avoid:**
  - **Partial agonists: Pentazocine & Propoxyphene**
  - **Meperidine (Demerol®)**

Question 4 - Maximum dose

What is the maximum recommended daily dose of opioid for chronic non-cancer pain?

1. 200 mg oral morphine or equivalent
2. 600 mg oral morphine or equivalent
3. 1200 mg oral morphine or equivalent
4. 2400 mg oral morphine or equivalent
5. As much as is necessary to control pain

Question 4 - Maximum dose

What is the maximum recommended daily dose of opioid for chronic non-cancer pain?

1. 200 mg oral morphine or equivalent
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5. As much as is necessary to control pain

Titrating Opioid Dose

- **Start at 50% to 100% of the recommended dose for acute or cancer pain**
- **At low doses, reassess weekly until titrated**
- **At higher doses (morphine equivalent ≥ 300mg), increase by ≤20% per month**
- **Start lower and increase more slowly with:**
  - **Impaired renal or hepatic function**
  - **Methadone**

Question 5 - Preventing Addiction

When treating chronic pain with opioids, the LEAST helpful strategy for preventing opioid addiction is:

1. Prescribing only long-acting opioids
2. Limiting the dose of opioids
3. Ensuring that opioids improve function
4. Using and enforcing written medication agreements (sometimes called contracts)

Medication Agreements

- One prescriber and one pharmacy
- Prescriptions must last as intended
- No after-hours refill requests
- Lost prescription policy
- Random urine drug screens
- Possible responses to violations
- Safe activities when drowsy
- Additional required care

Jean - Today

- Agreed to limit drinking - 1 beer/day
- Rx: transfermal fentanyl 25 μg/hr, Apply 1 every 3 days, #2 patches
- Transfermal fentanyl has:
  - Long duration of action - usually 3 days
  - Favorable impact on sleep
  - Low tamperability and diversion
  - Low incidence of constipation

Monitoring Opioid Recipients

Analgesia
Adverse Effects
Activity
Adherence

Passik, 2002

Monitoring Opioid Recipients

Anal
Adverse Effects
Activity (function)
Adherence (control)

CRITERIA FOR ADDICTION

Question 6 - Six days later

Six days later, Jean's pain has decreased to 5 to 7 out of 10. There have been no adverse effects. Her function is unchanged. She used the medicine as directed. At this time, you would:

1. Discontinue fentanyl
2. Continue fentanyl 25μg/hr
3. Increase fentanyl to 50μg/hr
4. Change to another long-acting opioid
5. Change to oxycodone/acetaminophen

Indications to Increase Opioid Dose

Analgesia	**Inadequate**
Adverse Effects	**Tolerable**
Activity	**Better or no worse**
Adherence	**Good**

Jean - 6 days later

Analgesia	**Pain ratings are 3 to 5**
Adverse Effects	**Mild sedation, resolving**
Activity	**Doing more housework**
Adherence	**Good**

Asks to retry physical therapy

Jean - Two Months Later

Analgesia	**Pain ratings are 0 to 3**
Adverse Effects	**None**
Activity	**Back to work x 1 mo, doing well in PT**
Adherence	**Good**

Wishes to discontinue fentanyl

Jean - Tapering Plan

- Transdermal fentanyl 25 μg/hr, #2, then discontinue
- Clonidine .1 mg, 1 to 2 tabs qid prn

Additional options:
OTC anti-diarrheal
OTC NSAID for muscle/joint pain
Sleeping aid

Question 7
Long-Term Treatment

If Jean had continued to require a long-acting opioid for adequate pain relief and return to work, you would have:

1. Insisted on a taper in 3 months
2. Insisted on a taper in 6 to 12 months
3. Referred Jean for to an addiction or pain specialist
4. Continued the opioid indefinitely

Long-Term Opioids

- Chronic pain is a chronic disease requiring ongoing treatment
- No tissue toxicity or documented harm with long-term opioids
- Most patients have no problem with tolerance to the analgesic effects
- For tolerance, consider opioid rotation

With Opioids, Consider:

- Non-opioid analgesics
- TCA's, anti-convulsants
- Exercise and other physical therapies
- Relaxation and distraction exercises
- Complementary/alternative modalities
- Treatments for [redacted]

5. Recommendations for Prescribers and Non-Prescribers

Optimizing Prescribing

- Assessment
- Treatment planning
- Patient selection for potentially addictive medications
- Medication selection for patients
- Medication titration
- Patient monitoring / Follow-up
- Documentation

Assessment

- Symptoms
- Function - physical, psychosocial
- Past treatments and results
- Other past history
- Psychiatric history, stresses, supports
- Substance use - current and prior
- Health care resources
- Physical examination
- Criminal justice and prescribing databases, where available

Treatment Planning

- Negotiate appropriate treatment goals
- Address the primary problem and related conditions
- Consider multiple treatment modalities serially or in parallel
- Assemble treatment team
- Ensure communication among treatment providers
- Set follow-up

Patient Selection for Potentially Addictive Drugs

- Failure of non-addictive drugs and non-pharmacologic modalities
- Access to non-pharmacologic modalities
- Severity of symptoms
- Severity of functional impact
- Urgency of addressing symptoms
- Substance use history
- Potential for safe self-administration
- Safety-sensitive occupations/child care
- Willingness to adhere to medication agreement

Selection of Potentially Addictive Drugs

- Consider emphasizing slow-onset, long-acting, medicines for baseline symptoms
- Consider the security of the delivery system
- Consider epidemiology of substance use
- Consider ease of monitoring
- Consider affordability
- Weigh considerations in light of risks and benefits

Safer Potentially Addictive Drugs

- Opioids for Chronic Pain:
  Fentanyl patch (Duragesic)
  Extended-release morphine
  (MS-Contin, Oramorph, Avinza, Kadian)
  Methadone
- Sedatives for Anxiety: clonazepam (Klonopin), clorazepate (Tranxene)
- Stimulants for ADD: Ritalin-SR, Adderal-SR

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Regulatory Scrutiny

Another common reason for discipline is continued prescribing despite poor outcomes and violations of medication agreements.

- Document aberrant behaviors and management
- When abuse or addiction are possible, refer for substance abuse assessment
- Discontinue potentially addictive medicines for continued poor outcomes and aberrant behaviors

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Non-Prescribers

- Most treatment team members are non-prescribers
- Help by:
  - Sharing observations
  - Contributing to problem-solving
  - Identifying other helpful resources
- For concerns about prescribing:
  - Speak with prescriber
  - Share current literature
  - Speak again with prescriber and request a referral
  - Consider report to medical board

Summary

- Prescription drug misuse, abuse, and dependence are increasing
- Treatments are similar to those for other substance use disorders
- Potentially addictive medicines are legitimate, effective treatments
- For those who need such treatments, measures can be taken to minimize addiction, abuse, and diversion